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1.0 Description of the Procedure

1.1 Reconstructive Surgery

Reconstructive surgery is any surgical procedure performed to raise a recipient to his or her optimum functioning level. The need may be a result of congenital deformity, an accident, infection, disease, or, in some cases, aging or a previous therapeutic process. Although a surgical procedure may have inherent cosmetic effects, it is considered to be primarily reconstructive in nature.

1.2 Cosmetic Surgery

Cosmetic surgery is performed to reshape normal structures of the body to improve the patient's appearance and self-esteem. Cosmetic surgery is intended primarily to preserve or improve appearance.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination****** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment. Service limitations on scope, amount, duration,

frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.

b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide,* sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid Billing Guide*:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 General Criteria

Medicaid covers reconstructive surgery when it is medically necessary and

a. the procedure is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

c. the procedure is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria: Reconstructive Surgery

Reconstructive surgery is covered when the procedure does one of the following:

a. Improves or restores physical function

b. Corrects significant deformity resulting from disease, trauma, or previous therapeutic process

c. Corrects congenital or developmental anomalies that have resulted in significant functional impairment or disfigurement

Some common examples of congenital abnormalities are birthmarks, cleft lip and palate deformities, hand deformities such as syndactyly (webbed fingers) or extra or absent fingers, and abnormal breast development (for example Poland's Syndrome).

Burn wounds, lacerations, growths, and aging problems are considered acquired deformities. For example, some older adults with redundant or drooping eyelid skin blocking their fields of vision might have eyelid surgery.

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

4.1 General Criteria

Reconstructive surgery is not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**

b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**

c. the procedure unnecessarily duplicates another provider's procedure; or

d. the procedure is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

4.2.1 Cosmetic Surgery

Cosmetic surgery, as defined in **Section 1.0,** is not covered. Psychiatric and/or emotional distress **is not** considered a medically necessary indicator for cosmetic procedures.

The following procedures are always considered to be cosmetic and therefore are not covered:

a. Augmentation of small breasts
b. Buttocks or thigh lifts
c. Diastasis recti repair
d. Ear piercing
e. Electrolysis for hirsutism
f. Excision/correction of frown lines
g. Excision of excessive skin and subcutaneous tissue (including lipectomy)
    1. Thigh
    2. Leg
    3. Hip
    4. Buttock
    5. Arm
    6. Forearm or hand
    7. Submental fat pad
    8. All other areas
h. Hairplasty for alopecia
i. Laser skin resurfacing
j. Psoralens ultraviolet A (PUVA) treatment for vitiligo

4.2.2 Reconstructive Surgery

Reconstructive surgery or procedures are not covered in the absence of documentation that the procedure was performed primarily to restore/improve function or to correct deformity resulting from congenital or developmental anomaly, disease, trauma, or previous therapeutic process.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

Prior approval is required for procedures that can be considered either cosmetic or reconstructive. The following information must be submitted with each prior approval request form to determine medical necessity:

e. The location and cause of the defect
f. Medical reasons for the procedure
g. Pre-surgery medical photographs of the defect
h. Listing of the CPT codes describing the procedures to be performed
i. Documentation of pain, infection, and irritation
j. Documentation of function that will be improved or restored

Note: Some reconstructive procedures have additional medical coverage criteria that are listed in separate policies.

5.2 Dental Reconstructive and Cosmetic Surgery

Dentists should refer to Clinical Coverage Policies 4A, *Dental Services*, and 4B, *Orthodontic Services.*

6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation, and are currently enrolled with the N.C. Medicaid program, are eligible to bill for reconstructive procedures when such procedures are within the scope of their practice.

7.0 Additional Requirements

7.1 Federal and State Requirements

All providers must comply with all applicable state and federal laws and regulations.

7.2 Records Retention

As a condition of participation, providers are required to keep records necessary to disclose the extent of services rendered to recipients and billed to the N.C.Medicaid program [Social Security Act 1902(a)(27) and 42 CFR 431.107]. Records must be retained for a period of at least five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107).

Copies of records must be furnished upon request.

The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).

8.0 Policy Implementation and Update Information

Original Effective Date: January 1, 1985

Revision Information:

Date	Section Updated	Change

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Providers should select the procedure code that accurately identifies the service performed. Providers should contact the fiscal agent to check service coverage or prior approval status.

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Inpatient hospital
Outpatient hospital
Office
Clinic
Ambulatory surgery center

F. Co-Payments

Recipients do not pay co-payments for surgical procedures.

G. Reimbursement Rate

Providers must bill their usual and customary charges.